



# KENTUCKY BOARD OF ALCOHOL AND DRUG COUNSELORS

P.O. Box 1360, Frankfort, Kentucky 40602

Email: [adc@ky.gov](mailto:adc@ky.gov) Website: <http://adc.ky.gov> Phone: (502) 782-8814

## **REGISTERED ALCOHOL AND DRUG PEER SUPPORT SPECIALIST APPLICATION CHECKLIST**

**Description:** Applicants typically already hold a current Temporary Alcohol and Drug Peer Support Specialist registration, and are ready to take the Alcohol & Drug Peer Support Specialist exam. Must have a High School Diploma or equivalent and have obtained all the required work experience, supervision, and training. Must attest to being in recovery for a minimum of two years from a substance related disorder.

1. **18 years of age** or older.
2. **Section 1** of application completed.
3. **Section 2** completed – describing education attainment of at least high school diploma/equivalent
4. **Provide a copy of a high school diploma, high school transcript, or equivalent** (unless it was previously provided for Temporary PSS). Let the Board Administrator know if your diploma/transcript is under a different last name than your current one.
5. **Section 3 completed** – Must have completed **500 hours** of experience working with persons having a substance use disorder, **25 hours** of which shall have been under a Board approved CADC or LCADC supervisor.
6. **Sign the Affidavit** at bottom of page 3.
7. **Sign & Date the Attestation of Recovery Form 2** – in which the applicant declares he/she has been in recovery for a minimum of 1 year from a substance-related disorder.
8. **Peer Support Specialist Training Verification Form 5** – Completed and documented 40 classroom hours of board-approved curriculum.
9. **Peer Support Specialist Supervisory Agreement Form 6** – Completed and signed by you and your Board Approved Supervisor, even if you are maintaining the same Board-approved supervisor of record.
10. **Peer Support Specialist Verification of Supervision Form 8** – documenting 25 hours of direct supervision signed by your Board Approved Supervisor including the 4 following domains: Advocacy, Ethical Responsibility, Mentoring & Education, Recovery & Wellness Support.
11. **Supervision Evaluation for Peer Support Specialist Form 9** – Completed and signed by your supervisor.
12. **Two letters of reference** from credentialed alcohol and drug counselors (CADC) or licensed clinical alcohol & drug counselors (LCADC).
13. **Submit payment** via check or money order made payable to the Kentucky State Treasurer (DO NOT SEND CASH)

Registration as an Alcohol and Drug Peer Support Specialist Application Fee      \$50.00

Registration as an Alcohol and Drug Peer Support Specialist Exam Fee      \$150.00

Registration as an Alcohol and Drug Peer Support Specialist Initial Issuance Fee      \$100.00

(Due after the examination has been successfully passed)

The completed application may be submitted with payment to the Kentucky Board of Alcohol & Drug Counselors via the PO Box address at the top of this form. Materials must be received by our office at least **10 DAYS PRIOR** to the next scheduled Board Meeting to ensure placement on the agenda. If this deadline is not met, your application will most likely be added to the next month's agenda.

## **IMPORTANT INFORMATION**

- **Incomplete applications will not be reviewed.**
- **Applicants will not be notified when their application arrives.**
- **Your check being cashed does not mean your application has been reviewed.**
- **It is the applicant's responsibility to ensure materials have been received by the Board Administrator.**
- **Applicants may contact the office to check on the status of their application. Email is best: [adc@ky.gov](mailto:adc@ky.gov)**

**Supervision occurring prior to August 24th, 2015** must have been with a Kentucky CADC in good standing with the Board and who had 2 years of post-certification experience along with appropriate documentation. Supervision sessions occurring **after** August 24<sup>th</sup>, 2015 must adhere to the new requirements: Both the supervisor and the supervision agreement must be approved by the Board first and temporary credential issued and active.

**When you start supervision:** It is best to document it on a regular basis. Keep good notes and maintain copies of everything for your own records. You should begin to document your supervision on the **PSS Verification of Supervision Form 8** found on the ADC website Forms & Documents. Your hours will need to be **submitted on an annual basis** (based on the issuance date of your temporary registration) using this form, along with the **Supervision Annual Report Form 14** via your online eServices account. The Supervision Annual Report Form 14 is also found on the ADC website under Forms & Documents.

**Supervision sessions:** Should not be documented as "blocks" of dates. List each session individually with the corresponding date and time and the board-approved supervisor's signatures.

**If you have long supervision sessions:** Document as much detail as possible what those sessions looked like and the activities completed or it could cause your Registered Alcohol & Drug Peer Support Specialist application to be deferred. Supervision sessions do not "typically" last 3+ hours and should not be occurring every day. For information regarding the difference between work experience and working alongside of your board-approved supervisor vs clinical supervision, please review the laws and regulations booklet found on the ADC website under LEGAL.

**Classroom Training Hours:** 1 academic credit hour equals 15 actual training hours. Therefore, if you took a 3 credit hour course related to alcohol/drug counseling, it would equal 45 actual training hours. You may also be able to count trainings you have already taken if relevant (out of state trainings, in state trainings, continuing education, other peer support trainings, etc.). For more information, please refer to the "Curriculum of Study" and "Continuing Education" regulations found on the ADC website under LEGAL. Your training hours will not be officially accepted by the Board until you submit the application for the Registered Alcohol & Drug Peer Support Specialist.

### ***Registered/Temporary Registered Alcohol & Drug Peer Support Specialists Scope of practice:***

Temporary Registered and Registered Alcohol and Drug Peer support specialists should not be performing clinical services (i.e.: psycho-socials and treatment plans are clinical functions they should not be doing). They are not to be mini-counselors. They are instead advocates, educators and coaches. Please refer to the following information from SAMHSA:

*"Recovery support services are non-clinical services that are used with treatment to support individuals in their recovery goals. These services are often provided by peers, or others who are already in recovery. Recovery support can include: Transportation to and from treatment and recovery-oriented activities; Employment or educational supports; Specialized living situations; Peer-to-peer services, mentoring, coaching; Spiritual and faith-based support; Parenting education; Self-help and support groups; Outreach and engagement; Staffing drop in centers, clubhouses, respite/crisis services, or warm lines (peer-run listening lines staffed by people in recovery themselves; Education about strategies to promote wellness and recovery."*

<https://www.mansfieldumadaop.com/treatment/recovery-support-services>

### **NEXT STEPS:**

1. Print off and read through the Board's Laws and Regulations Booklet found at <http://adc.ky.gov>.
2. You must remain under your Board-approved supervisor of record and maintain the minimum required monthly supervision over the full course of your registration with this Board; even after you pass the PR examination and have your full registration officially issued by the Board.
3. Read the Board's supervision regulation in full 201 KAR 35:070 Supervision Experience found on the ADC website under LEGAL.
4. If approved, you will receive a letter or email approximately 2 weeks following the Board meeting with instructions on how to register for the computer based "PR/Peer Recovery" exam.
5. Begin preparing to take the IC&RC Peer Recovery (PR) computer exam.

### **EXAM PREPARATION, STUDY MATERIALS & PRACTICE EXAMS**

<http://internationalcredentialing.org/exams> (PR / Peer Recovery Exam)

The Kentucky Board offers computer-based examinations. Applicants may take the computer exam any date, time or location of their choosing. The examination is multiple choice. Whenever your application is approved, you will be given instructions on how to finalize registration on your own. The exam must be scheduled within the one (1) year from the date of approval.

Peer Support Specialist PR Examination Fee

**\$150.00**

6. You will know on the day you take your computer exam if you have passed or not. If you have not passed the exam, the Board will send you instructions for taking the exam a second time. If you have failed the exam two or more times, a board-approved remediation plan is required as co-signed by your supervisor(s).

After you pass the exam, the Board will receive your score report the next business day. We will then send your passing scores to your email along with a request for you to send in your initial Registration fee. Upon receipt of your fee, your Registered Alcohol & Drug Peer Support Specialist number will be issued within approximately 10 business days. Your registration will not need to be renewed for three years; however, please review the renewal, continuing education requirements and the requirements for training program in suicide assessment, treatment, and management 201 KAR 35:040 found on the ADC website under LEGAL.

Peer Support Specialist Initial Registration Fee

**\$100.00**

7. It is your responsibility to keep the Board informed of any change in address, e-mail, name, contact information, employment and supervision changes. Changes can be submitted via your eServices online account. Click the RECORD CORRECTION link from the main menu. Important Board correspondence will be emailed to you.

**Do not rely on forwarding services of the U.S. Postal Service.**

**8. One year from the issuance of your registration** you must submit a **Supervision Annual Report Form 14** and **Peer Support Supervision Verification Form 8** to the Board. Supervision is due on a yearly basis containing only supervision received in the previous one (1) year period.

#### **Annual Report Forms to Submit and Where to Locate the Forms:**

1. The **Supervision Logs/ PS Supervision Verification Form 8** is located under Forms & Documents on the ADC website.
2. The **Supervision Annual Report Form 14** is located on the ADC website under Forms & Documents. Supervisees with annual reports due are to submit documentation via mail to:

**Kentucky Board of Alcohol & Drug Counselors**

**PO Box 1360**

**Frankfort, Kentucky 40602**

Should the Board request additional documentation, the licensee will receive email correspondence stating the Board's request for additional information. If the Supervision Annual Report Form is received and accepted, the supervisee will receive such approval email correspondence.

***It is a shared responsibility between supervisee and supervisor that timely documentation is submitted to the Board.***

**9. Request to have two (2) Board-approved supervisors:** If you would like two Board-approved supervisors, an additional Supervisory Agreement shall be submitted to the Board for approval. 201 KAR 35:070 states **each** supervisor of record shall provide supervision to the supervisee no less than two (2) hours, two (2) times a month. 201 KAR 35:070 Section 7 states if a supervisee has more than one (1) board-approved supervisor, the supervisors shall be in direct contact with each other at least once every six (6) months, and they shall provide supervisory plans and reports to the board and copies to each other. Your request to have 2 supervisors shall include detailed information as to how the supervisors shall communicate and coordinate with each other in providing the required supervision.

***Request to change or terminate your Board-approved supervisor:*** If you need to add, change, or remove your supervisor(s) of record, these changes must be submitted via your online eServices account. 201 KAR 35:070 Section 3(2) states upon a change of supervisor, a new Supervisory Agreement shall be submitted by the supervisor and supervisee to the Board for approval. Upon termination of the supervisor-supervisee relationship, the **Peer Support Supervision Evaluation Form 9** and copies of your **Supervision Log Form 8** shall be submitted to the Board within 30 days of termination.



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P.O. Box 1360, Frankfort, Kentucky 40602 ~ 500 Mero St., 2 SC 32, Frankfort, Kentucky 40601

Phone (502) 782-8814 ~ <http://adc.ky.gov>

- APPLICATION FOR:**
- |  |     |
|--|-----|
| TEMPORARY REGISTRATION AS PEER SUPPORT SPECIALIST        | ( ) |
| REGISTRATION AS PEER SUPPORT SPECIALIST                  | ( ) |
| CERTIFIED ALCOHOL AND DRUG COUNSELOR ASSOCIATE I         | ( ) |
| CERTIFIED ALCOHOL AND DRUG COUNSELOR ASSOCIATE II        | ( ) |
| TEMPORARY CERTIFICATION AS AN ALCOHOL AND DRUG COUNSELOR | ( ) |
| CERTIFICATION AS AN ALCOHOL AND DRUG COUNSELOR           | ( ) |
| LICENSED CLINICAL ALCOHOL AND DRUG COUNSELOR ASSOCIATE   | ( ) |
| LICENSED CLINICAL ALCOHOL AND DRUG COUNSELOR             | ( ) |
| LICENSED ALCOHOL AND DRUG COUNSELOR                      | ( ) |

## SECTION 1 – APPLICANT INFORMATION

1. \_\_\_\_\_
- |                            |                |            |            |
|----------------------------|----------------|------------|------------|
| Name: First                | Middle         | Last       | Maiden     |
| _____                      |                |            |            |
| Social Security Number     | Date of Birth  | Home Phone | Cell Phone |
| _____                      |                |            |            |
| Mailing Address: Street    | City           | State      | Zip Code   |
| _____                      |                |            |            |
| Employer                   | Business Phone |            |            |
| _____                      |                |            |            |
| Employer's Address: Street | City           | State      | Zip Code   |
| _____                      |                |            |            |
| Home Email                 | Business Email |            |            |
| _____                      |                |            |            |
2. Have you had a credential in Kentucky or any other state that has ever been suspended or revoked?  
☐ YES ☐ NO If yes, give details: \_\_\_\_\_
3. Have you been convicted of a felony or plead guilty, including an Alford plea (other than minor traffic violations) under the laws of the United States in the last 5 years? ☐ YES ☐ NO If yes, what offense?  
\_\_\_\_\_(If yes, send supporting documentation.)
4. Are you credentialed as an Alcohol or Drug Counselor in any other state? ☐ YES ☐ NO  
If yes, what state? \_\_\_\_\_ Type of Credential? \_\_\_\_\_
5. Have you ever been discharged or forced to resign for misconduct or unsatisfactory service from any position from any professional training program, or from the program of any university? ☐ YES ☐ NO  
(If yes, send supporting documentation.)
6. Have you ever been sanctioned by the Kentucky Board of Alcohol and Drug Counselors or by any other credentialing board or professional associations for ethical misconduct? ☐ YES ☐ NO  
(If yes, send supporting documentation.)

7. Are you currently on active military duty? ☐ YES ☐ NO

8. Are you or your spouse a member of the United States military, Reserves, or National Guard, or are you or your spouse a veteran? ☐ YES ☐ NO

If yes, do you currently hold or recently held an equivalent credential issued by another state, the District of Columbia, or any possession or territory of the United States? ☐ YES ☐ NO

If yes, please answer the following questions:

Has your credential issued by another state, the District of Columbia, or any possession or territory of the United States been expired for more than two years? ☐ YES ☐ NO

Is your credential issued by another state, the District of Columbia, or any possession or territory of the United States in good standing? ☐ YES ☐ NO

Has your credential issued by another state, the District of Columbia, or any possession or territory of the United States been suspended for disciplinary reasons? ☐ YES ☐ NO

The United States military service member, Reserves or National Guard member, veteran, or spouse shall submit:

(1) Proof of issuance of a valid license, permit, certificate, or other document issued by another state, the District of Columbia, or any possession or territory of the United States that is active or has been expired for less than two (2) years;

(2) Proof that the valid license, permit, certificate, or other document issued by another state, the District of Columbia, or any possession or territory of the United States is in good standing or was upon the date of expiration; and

(3) His or her DD-214 form or other proof of active or prior military service with an honorable discharge, discharge under honorable conditions, or a general discharge under honorable conditions.

## SECTION 2 – APPLICANT EDUCATION

School	Name and Location	Dates Attended	Date of Graduation	Number of Hours	Degree Obtained
High School/Equivalent					
Baccalaureate					
Master's					
Doctoral					

**Submit proof of your highest education achieved:**

- High school / equivalent - submit a copy of your diploma or certificate.
- Other higher education - submit official transcript sent from registrar of the college or university.

**SECTION 3 – WORK EXPERIENCE (Attach Additional Related Experience If Needed)**

Name of Employer: \_\_\_\_\_  
Title or Position: \_\_\_\_\_  
Employment Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
Address of Employer: \_\_\_\_\_  
Clinical Supervisor: \_\_\_\_\_ Credential Number: \_\_\_\_\_  
Total Number of Work Hours per Week Related to Alcohol and Drug Clients: \_\_\_\_\_  
Describe Work Duties Related to Alcohol and Drug Clients: \_\_\_\_\_  
\_\_\_\_\_

Name of Employer: \_\_\_\_\_  
Title or Position: \_\_\_\_\_  
Employment Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
Address of Employer: \_\_\_\_\_  
Clinical Supervisor: \_\_\_\_\_ Credential Number: \_\_\_\_\_  
Total Number of Work Hours per Week Related to Alcohol and Drug Clients: \_\_\_\_\_  
Describe Work Duties Related to Alcohol and Drug Clients: \_\_\_\_\_  
\_\_\_\_\_

**AFFIDAVIT**

I do hereby certify under penalty of law, that the information contained herein is true, correct and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose such misrepresentation or falsification, my application could be rejected or my certification revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the Board.

\_\_\_\_\_  
Applicant's Signature (Do not type or print)

\_\_\_\_\_  
Date



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## ATTESTATION OF RECOVERY

TEMPORARY REGISTRATION AS PEER SUPPORT SPECIALIST ( )

REGISTRATION AS PEER SUPPORT SPECIALIST ( )

Pursuant to KRS 309.0831(7), I attest to being in recovery for a minimum of one (1) year from a substance-related disorder.

\_\_\_\_\_  
Signature (Must not be printed or typed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name





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## **PEER SUPPORT SPECIALIST** **ALCOHOL / DRUG TRAINING VERIFICATION FORM**

In accordance with 201 KAR 35:050, Section 1 (1), an applicant seeking registration as an alcohol and drug peer support specialist shall complete forty (40) classroom hours, which shall include:

1. Sixteen (16) hours of interactive training in ethics of which eight (8) hours shall consist of face-to-face ethics training;
2. Three (3) hours of domestic violence training;
3. Two (2) hours of training in transmission, control, treatment and prevention of the human immunodeficiency virus;
4. Ten (10) hours of advocacy training;
5. Ten (10) hours of training in mentoring and education; and
6. Ten (10) hours of training in recovery support

(Make as many copies of these pages as needed. Number each page.)

### **ETHICS TRAINING (16)**

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours: \_\_\_\_\_

### **HIV TRAINING (2)**

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

Total Number of Hours: \_\_\_\_\_

**MENTORING AND EDUCATION TRAINING (10)**

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

**Total Number of Hours:** \_\_\_\_\_**RECOVERY SUPPORT TRAINING (10)**

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

**Total Number of Hours:** \_\_\_\_\_

**ADVOCACY TRAINING (10)**

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

**Total Number of Hours:** \_\_\_\_\_**DOMESTIC VIOLENCE TRAINING (3)**

Title of Course	Dates of Attendance	Entity Offering Training	No. of Actual Training Hours

**Total Number of Hours:** \_\_\_\_\_



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**PEER SUPPORT SPECIALIST  
SUPERVISORY AGREEMENT**

**To Be Completed By Applicant and Supervisor**

**INSTRUCTIONS**

1. This form is to be used with Microsoft Word.
2. Press the TAB key to skip to the next field.
3. Once you have completed the form, you must print the form, and apply your handwritten signature. Forms submitted without the appropriate signatures will be returned.
4. The completed form may be submitted to the Kentucky Board of Alcohol and Drug Counselors either by mail to P.O. Box 1360, Frankfort, Kentucky 40602 or by delivery to 500 Mero Street, 2SC32, Frankfort, Kentucky 40601.

**SECTION 1  
APPLICANT INFORMATION**

First Name / /	Middle Name ( ) -	Last Name ( ) -
Social Security Number	Home Telephone	Work Telephone
Email Address		
Street Address		
City	State	Zip Code

**SECTION 2  
SUPERVISOR INFORMATION**

First Name	Middle Name	Last Name
Email Address		
Street Address		
City ( ) -	State	Zip Code
Telephone Number	Type of License/Certification Held and Number	
/ /	/ /	
Date of issue (attach a copy)	Expiration Date (Attach a copy)	
Date of Board Approved Supervision Training (Attach copy of certificate of attendance)	Number of Supervisee's Currently Providing with Board Approved Supervision	

**SECTION 3**  
**INFORMATION RELATED TO SUPERVISED EXPERIENCE**

Applicant Name \_\_\_\_\_

Name of organization or agency where experience will be gained (complete a separate form for each setting.)

\_\_\_\_\_

Street Address of Organization or Agency

\_\_\_\_\_

City

State

Zip Code

Average number of hours expected to be gained per week: \_\_\_\_\_

Type of Setting: ☐ State/Government Agency ☐ Hospital  
☐ Non-Profit ☐ DUI/Private Practice  
☐ School ☐ Rehab Center

Type of peer support/counseling experience to be gained (check all that apply):

☐ Rehabilitation Center ☐ Judicial/Corrections  
☐ Child & Adolescent ☐ Individual Counseling  
☐ Adult ☐ Group Counseling  
☐ Family Treatment  
☐ Other

Describe

Describe specifically, and in detail, what work experience will be obtained to meet the criteria for Recovery Support work experience in the four (4) domains: (1) advocacy; (2) ethical responsibility; (3) mentoring and education; and (4) recovery and wellness support. Work experience shall not include counseling. (201 KAR 35:070)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe specifically, and in detail, how supervision will focus on recovery support in the four (4) domains: (1) advocacy; (2) ethical responsibility; (3) mentoring and education; and (4) recovery and wellness support.(201 KAR 35:070)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, as applicant, affirm that all information provided by me on this form is true and accurate and I affirm the following:

- That I have read the board Law and Regulations related to supervised experience and that all supervised experience will be completed in accordance with board rules;
- That I will meet with my supervisor at a minimum of 2 hours twice a month of documented supervised experience;
- That I will abide by all rules of the board, including ethics requirements;
- That I understand the temporary registration or registration is only valid while I practice under supervision;
- That I notify the board if this supervisory arrangement is terminated; and
- That I understand any additional supervisors and settings shall be approved by the board in advance.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

**This agreement shall not be effective until the board has issued the letter approving the agreement.**

I, as the board approved supervisor of the above named applicant, affirm that all information provided by me on this form is true and accurate and I affirm the following:

- That all supervised experience will be completed in accordance with the Law and Regulations related to supervised experience and all subsequent board rules.
- That I will provide supervision to the above name applicant at least 2 hours twice a month of documented experience.
- That I understand the full professional responsibility for services of the supervisee shall rest with the supervisor.
- That I understand the supervisory arrangement is only valid while my credential remains in good standing.
- That I will notify the board if the supervisory arrangement is terminated.
- That I understand that I shall not serve as a supervisor of record for more than twelve persons obtaining experience for peer support/certification/licensure at the same time.

\_\_\_\_\_  
Signature of Supervisor

\_\_\_\_\_  
Date

**APPLICANT AND SUPERVISOR SHOULD KEEP A COPY OF THIS FORM FOR RECORDS**

**BOARD USE ONLY**

☐ Approved by \_\_\_\_\_ Date: \_\_\_\_\_  
(Initials of Reviewer)

☐ Denied by \_\_\_\_\_  
(Initials of Reviewer)

☐ Deferred by by \_\_\_\_\_ Date: \_\_\_\_\_  
(Initials of Reviewer)

\_\_\_\_\_

\_\_\_\_\_



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## PEER SUPPORT SPECIALIST VERIFICATION OF SUPERVISION

**This section must be completed by the applicant and signed by the supervisor. Make as many copies of these pages as needed. Number each page.**

Documentation of 25 hours of direct supervision by a Board-Approved Certified Alcohol and Drug Counselor or a Licensed Clinical Alcohol and Drug Counselor must be documented in the four domains: 1. Advocacy; 2. Mentoring/Education; 3. Recovery/Wellness Support; or 4. Ethical Responsibilities. Methods of supervision include: face-to-face, video, or observation.

DATE OBSERVED	Domain Covered	LENGTH OF SESSION	METHOD OF SUPERVISION	SUPERVISOR'S SIGNATURE (Must be legible)

Applicant Name \_\_\_\_\_

Total Number of Hours \_\_\_\_\_



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## **SUPERVISION EVALUATION FOR PEER SUPPORT SPECIALIST**

(Completed by each Supervisor)

This form must be entirely completed by each supervisor of qualifying experience. Please pay special attention to the number of hours of direct clinical supervision and percentage of applicant's time allotted to chemical dependency clients.

Applicant's Name \_\_\_\_\_

Applicant's Address: \_\_\_\_\_

Clinical Supervisor: \_\_\_\_\_ Credential Number: \_\_\_\_\_

Current Address: \_\_\_\_\_

Date of Issue of Certification: \_\_\_\_\_ Supervisor's Day Phone Number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Program or agency where you supervised the applicant: \_\_\_\_\_

I have supervised the applicant's work from \_\_\_\_\_ to \_\_\_\_\_, which includes approximately  
(Date) (Date)  
hours of face to face supervision per month for a total of \_\_\_\_\_ hours.

The approximate percentage of his/her time spent in delivery of services to substance abuse clients: \_\_\_\_\_%

### **PERSONAL ATTRIBUTES:**

Evaluate the applicant as you observe(d) him/her in the following areas of interpersonal relationship with clients:  
(Please use appropriate number as indicated on scale.)

1	2	3	4	5	6
/	/	/	/	/	/
Weak	Fair	Average	Above Average	Superior	NA

- \_\_\_\_\_ A. Respect for client.
- \_\_\_\_\_ B. Care and concern for client.
- \_\_\_\_\_ C. Genuineness with client.
- \_\_\_\_\_ D. Empathy with client.
- \_\_\_\_\_ E. Flexibility with client.
- \_\_\_\_\_ F. Spontaneity with client.
- \_\_\_\_\_ G. Capacity for appropriate self-disclosure.
- \_\_\_\_\_ H. Sense of immediacy.
- \_\_\_\_\_ I. Concreteness.



Applicant's Name \_\_\_\_\_

### Performance Competencies

Evaluate the applicant as you feel he/she demonstrates his/her abilities in the area of recovery support. Mark the rating most nearly descriptive of the applicant's demonstrated skills using the scales given.

1	2	3	4	5	6
/	/	/	/	/	/
Weak	Fair	Average	Above Average	Superior	NA

- \_\_\_\_\_ A. Advocacy
- \_\_\_\_\_ B. Ethical Responsibility
- \_\_\_\_\_ C. Mentoring and Education
- \_\_\_\_\_ D. Recovery and Wellness Support

### PROFESSIONAL AND ETHICAL CONDUCT:

1. Employment of fraud or deception in applying for a registration: ☐ Yes ☐ No. If yes, please comment:  
Comment: \_\_\_\_\_
2. Practicing recovery support or advocacy under a false or assumed name or the impersonation of another credential holder of a like or different name. ☐ Yes ☐ No. If yes, please comment:  
Comment: \_\_\_\_\_
3. Habitual abuse of any mood-altering chemical substance to such an extent as to interfere consistently with the competent performance of his/her duties. ☐ Yes ☐ No. If yes, please comment:  
Comment: \_\_\_\_\_
4. Misrepresentation of one's professional credentials: ☐ Yes ☐ No. If yes, please comment:  
Comment: \_\_\_\_\_
5. Failure to adhere to KRS 309.080 to 309.089: ☐ Yes ☐ No. If yes, please comment:  
Comment: \_\_\_\_\_

Describe what you believe to be significant strengths and / or deficiencies of the applicant (attach additional pages, if needed):

\_\_\_\_\_

I recommend \_\_\_\_\_ for registration as a peer support specialist.

Applicant's Name

I do not recommend \_\_\_\_\_ for registration as a peer support specialist.

Applicant's Name

Signature: \_\_\_\_\_ Credential: \_\_\_\_\_

Current Address: \_\_\_\_\_

\_\_\_\_\_

Date Signed: \_\_\_\_\_